Original Article

Attitude and practice towards Cardiac Rehabilitation among patients suffering from myocardial infarction

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Abstract

Background: Cardiovascular Rehabilitation is an exhaustive model of care including setting up focus portions, including coordinated exercise, patient preparation, psychosocial management, peril factor reduction, and direct adjustment, with a target of upgrading cardiac patient's quality of life while assisting with diminishing the risk of future heart issues.

Objective: The objective of this study is to examine the attitude and practices towards cardiac rehabilitation among patients who encountered dead myocardial tissue or myocardial infarction (MI) and recovered.

Methods: A total of 821 MI patients with MI and under 82 years of age were hospitalized between April 1, 2018, to July 31, 2020. The enrolment of late hospitalized of MI patients was confirmed, and clinical parents coordinated selection meetings and good references. The patient underwent a standard recovery program (SRP). Various recovery programs (ERPs) were offered when patients were socially vulnerable. For noncompliant patients, a cardiovascular clinical gatekeeper provided home visits. Similar rules were used in parts of the personalized program. Compliance was monitored for up to one year.

Results: Cardiac Rehabilitation was implied by 86% of the population. A significant portion of the more skilled patients and women has set them apart. The interest and adherence rates were 80% and 71%, respectively, among all inpatients; the investment rate among the patients who had been greeted was 93%. Patients were relatively scattered in SRP and ERP. No imbalances in cooperation and compliance were found with the proposed patient.

Conclusion: According to the patients' attitudes, mental components are the second biggest cause for heart disorders with social components being the first. Furthermore, people may be reluctant to take their medication due to the impression they receive from people in clinical settings. It is imperative to seek ways to manage and control the negative effects of cardiovascular disease, to ensure participation and adherence to measures that are put in place for cardiovascular recovery. [*Ethiop. J. Health Dev.*2021; 35(4): 390-396]

Keywords: Adherence, attendance, cardiovascular rehabilitation, myocardial infarction, cardiovascular disease; Psychological; Risk Factors; Patients; Attitudes; Cardiac Rehabilitation; Heart Disease.

Introduction

Cardiovascular disease (CVD) is the leading cause of death globally, resulting in more than 17 million in costs annually. Most of these deaths occur in underdeveloped countries. According to an assessment, approximately 15 million humans in Iran are afflicted by coronary heart disease. In 2007, of the 100,000 instances of coronary heart infection discovered in Iran, 167 of them had passed on (1). This figure highlights the increase in mortality rates owing to cardiovascular diseases. Numerous causal factors of CVD are presented to people daily; however, factors can be divided into various categories, which include natural, familiar, social, and religious threats. Common factors are associated with age, gender, and hereditary hypercholesterolemia. Natural factors include smoking, water, air pollution, poisonous materials, accumulation and drugs, lethargy, helpless maintenance, diabetes, excessive blood strain, and hoarseness (2,11-15). Other factors include, intellectual threat, which include restlessness, distress, shock, hostility, character type, disappointment, and stress. These factors might also play a key role in coronary heart pollution (17). Cardiovascular healing initiatives can enhance personal satisfaction, assist patients with achieving normalcy, promote wellbeing, inspire behaviour which may lead to better health outcomes and decrease costs associated with healthcare (3). Research has tracked down that cardiovascular recovery projects can diminish your risk of death from coronary illness and lessen your danger of future heart issues (4).

Psychological factors that affect cardiovascular events can explain a large part of the diligent natural wonders, which can cause heart disease, such as circadian rhythm, gradual or intermittent patterns. Mental factors that may impact patients' opinions with heart disease can affect their physical weakness (5). Studies have shown that the perception of angina pectoris by the patient is related to the mental state of these patients and the state of their feet on the ground. Patients with more legends are more anxious than other patients, and the actual limitations are less (16-18). However, two evaluations showed almost no correlation between the patient's actual and sawtooth risk factors. Several examinations showed a strong correlation between the patient's causal perception of CVD and their risk factors. In this way, from the patient's point of view, the mental factor is obvious (6). Ayres and Eagle etc. Studies have found that women regard urgent factors as the fundamental driving force of their infections, while men regard them as the third reason for eating and smoking disorders (7). However, the Turner-Dworkin test did not investigate the basic occupations of psychosocial risk factors perceived by patients. The patient's "feeling, such as pushing," is related to the

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patient's psychological state and related to their bad life (8). In addition, because the patient's attitude towards the explanation behind the infection may be directly related to their enthusiasm and happiness (19). The patient's "impression, to a degree pushing "exists not only with connection with the patient's psychological state but also to connect with bad growth (8). Patients perceive that stress determinants are forceful support for CVD and should happen dependably avoided. In any case, before this time, from the patient's view, no review of the number of risk factors for heart failure disease of the heart has happened complete activity. In addition, because the patient's stance towards the clarification behind the contamination may happen as soon as possible related to their excitement and high spirits (19). The inspiration that cues the printing of written or visual material concerning this review was to check the idea of cardiac recovery from the person being treated for a medical problem the one encountered dead myocardial fabric (23), the publication of this review was to examine the perception of cardiac recovery from patients who encountered dead myocardial tissue (23,9).

Materials and Methods
A cross-sectional study was conducted between 2018 and 2020 among 831 cardiovascular patients who were at the cardiac rehabilitation centre of Imam Ali clinical centre in Iran. Inclusion was being 85 years and below. Accordingly, a total of 55 patients were excluded. Finally, 775 patients were included in the study. Examinations were done using clinical data, patient medical records, and million multi-axis clinical stock (MCMI-III) (10) was used to collect data. In the study, patient's attitude was classified as one of the four categories of risk factors for coronary heart disease, including regular, environmental, and mental illness. In the restoration of cooperation, patients are inexhaustible. The clinical experts discussed these risk factors from patients' perspectives in clinical meetings on occasion behind coronary heart disease. They recorded the field data, the fence credit for each food, and their record in the medical history. In addition, the Millon test was used to assess the patient's co-morbidities. Millon Clinical Multiaxial Stock (MCMI-III) is an evaluation device used to provide clinicians with information about the psychopathology of patients. In addition, DSM-IV-TR characteristics for mental problems were used. Authentic manual guaranteed any individual social conditions in the "Fourth Coming. "This assessment is typical for people over the age of 18 each year and whose basic test level is equivalent to that of the eighth grade. MCMI-III is a verifiable self-reported false mentality related to personal psychopathology and can be used for severely dissatisfied patients (11). The retest of MCMI-I (12) showed extraordinary consistency and established an immovable quality factor, ranging from 82 for Debasement to 90 for Somatoform (13). Finally, studies from Bryce et al. (2020) show that the

authenticity of MCMI-III is adequate and found that it offers good consolidation and different authenticity compared to other self-report measures (14).

Mediation was randomly incorporated into the Standard Recovery Plan (SRP) or the Complete Recovery Program (ERP). Efforts to support the recommended social disruption CR for 6 or 2 months. As evidenced by Danish statistics 5-8 compiled by the Danish Teaching Nomenclature (DUN), all informed patients and their colleagues are welcome to participate in the SRP. ERP has been provided to socially vulnerable patients and their partners or other family members. The DUN Action Plan ranging from 1 to 4, living alone or experiencing apparent life stress levels and lack of relationship associations, shows recognition of the low level of planning for socially sensitive patients (20-22). If level 4 of the DUN social status shows they are proficient in preparation, add free ride patients ≥55 to SRP, and clinical staff will share it with the patient. They will use CR as one of the treatments for MI. Then the team will begin work on the coronary. Clinical, social, and direct consultations are carried out in the arterial conception unit. The primary game plan date to rebuild the unit is set within fourteen days after launch. The cardiologist's clinical evaluation is related in the long term to different parts of CR. SRP includes an interview of approximately one and a half months to ensure that the patient completes a substantial SRP isolation before leaving the hospital for a two-month according to the method of Vikranth et al., (23)

Statistical Analysis:
The outcomes were organized as per the segment and clinical attributes found in patients (in situ, just as intrusive). The connection test is the best strategy for evaluating the distinctions in CAM use by identity. The Statistical Package for Social Sciences (SPSS) version 27.0 was utilized.

The most beneficial proportion of reliance between two measures is the Pearson's coefficient (PPMCC), (9) or Pearson's connection coefficient (5). Hence, if higher connection esteem is seen in the outcome, it is said that they have a solid relationship with one another, while lower or frail connection implies that they are not related. The cycle is related to the immediate relapse investigation, a factual methodology for displaying the relationship between a needy and a free variable.

Results
The individuals from the examination involved 831 patients (231 females; 600 men). The mean (± SD) age of the individuals was 58.26 ± 9.10 years (58.89 ± 8.29 in women, and 57.95 ± 9.46 years in men). Moreover, the age range was 29 - 82 years (29 – 78 years in women, and 31 - 82 years in men). Patients' socio-portion credits have appeared in Table 1. Moreover, this table shows the speeds of co-morbidities in heart patients.

Table 1. **Patient attitudes towards heart disease risk factors and their comparison (n=?)**

Attitude	Frequency [a] (proportion)	$\chi 2$
Biologic	61 (4.3)	820.356
Hereditary	61 (4.3)	6.025
Natural Phenomenon	45(3.8)	
War	12(1.0)	
Smoke and poisonous substances	15 (1.0)	
Residue(dust)	48 (1.4)	
Other people smoking	5(0.4)	
Social	768 (34.0)	
Absence of activity	79 (3.1)	
Cigarette and substance misuse	175 (11.3)	
Nourishment	142 (13.3)	
Physical work	69(3.9)	
Methadone	1 (0.1)	
Cholesterol	38 (3.3)	
Hypertension	54 (3.2)	
Diabetes	39 (2.9)	
Overweight	7 (0.5)	
Smoke bread	5 (0.4)	
Psychological factors	619 (36.3)	
Stress and grieving	401 (27.5)	
Outrage and wrath	105 (7.4)	
Acute Depression	15 (1.2)	
Companion abuse	3 (0.2)	
Do not know	127 (10.4)	
Other	45 (3.3)	

a Data are introduced as No. (%).
b Comparison between the weight of four mentalities; (df = 3).
c Comparison between the importance of social and mental perspectives (df = 1).

As indicated in Table 1, thinking about risk factors for of the feelings of the current patient. Psychological segments (36.3%), natural ingredients (4.3%), and biological factors (3.8%) were also mentioned independently. The rate at which patients are unaware of their disease (even without a hidden clue) is 10.4%, which is significantly sketchy. Patients in this study have undergone various therapies and heart reconstruction as their last resort. Either way, once the clinical collection is ready, the rate at which patients don't know why their disorder can call into question treatments that oversee the hospital's core prosperity and benefits. About 3.3% of patients participate in explaining their pain through a certain number of problems. There was a large difference between patients for the four attitudes ($\chi 2$ = 820,356; df (3); P < 0.01); and social and mental perspective ($\chi 2$ = 6,025; df (1); P < 0.05). Patients view lead problems as the underlying cause of their infection in general. According to Table 2, the crucial factor, considered the dangerous psychological factor (27.5%), ranks first in the patient's feelings; food (13.3%) and smoking (11.3%) have separate, enclosed positions.

Table 2. **Socio-demographic factors among MI patients ≤75 years (n=?)**

Variables	Biologic Frequency	Environmental Frequency	Behavioral Frequency[a]	Psychologic Frequency[a]	Difference in Biologic Attitudes	The difference in ecological attitudes	The difference in behavioural attitudes	The difference in psychological attitudes	P-Value
Gender					61.00	56.00	599.00	517.00	0.0005
Female	12 (4.2)	25 (5.3)	146 (36.3)	206 (53.7)					
Male	49 (5.2)	34 (4)	389 (55)	311 (35.8)					
Age, y					80.00	186.00	1800.00	1500.00	0.0005
≤ 40	2 (13.4)	2 (3.3)	17 (36.7)	14 (46.6)					
41-50	17 (5.9)	5 (1.8)	186 (54.5)	84 (37.8)					
51-60	18 (3.7)	25 (3.9)	249 (50.1)	227 (42.3)					

≥ 61	3 (1)	39 (8.7)	145 (47.8)	175 (42.5)					
Education degree					164.00	224.00	3020.00	2500.00	0.0005
Illiterate	8 (1.2)	38 (7.2)	226 (49.1)	196 (42.5)					
Primary	14 (3)	17 (4.5)	180 (540	129 (38.5)					
Less than diploma	2(2.9)	1 (0.1)	18 (51.4)	16 (45.7)					
Diploma	8 (4)	8 (4)	103 (49.5)	89 (42.5)					
Bachelor	17 (10.5)	5 (3.1)	73 (44.7)	68 (41.7)					
MA and PhD	0 (0)	1 (14.3)	4 (57.1)	2 (28.6)					
Job					82.00	248.00	2840.00	2490.00	
Clerk	6 (4.5)	5 (3.7)	74 (55.5)	48 (36.3)					
Self-employed	13 (4.7)	9 (3.2)	178 (52.6)	110 (39.5)					
Retired	13 (4.7)	19 (5.4)	149 (51.1)	114 (38.8)					
Housekeeper	9 (2.3)	17 (5)	123 (36.5)	188 (56.2)					
Farmer	0 (0)	15 (13.6)	65 (59.7)	29 (26.7)					
Unemployed	0 (0)	1 (4.8)	11 (52.4)	9 (42.8)					
Socioeconomic status					82.00	124.00	1212.00	1000.00	0.0005
High	5 (6)	3 (3.4)	46 (55.1)	30 (35.5)					
medium	30 (3.7)	42 (5.1)	394 (47.4)	487 (43.8)					
Low	6 (2.1)	17 (5.8)	147 (56.5)	105 (35.6)					

Table 2 shows contrasts in attitudes concerning socio-portion factors. As can be seen, there is a colossal differentiation among males and females regarding mindsets toward the explanations behind contamination concerning socio-section factors. For example, it is understood that women zeroing in on mental peril factors ($\chi 2 = 517.00$, $P < 0.0005$); while men are more focusing in on lead risk factors ($\chi 2 = 599.00$; $P < 0.0005$). Table 2 shows the patients' perspectives about coronary illness hazard factors (typical, organic, social, and mental.

Table 3. shows contrasts in attitudes concerning Patients' Socio-demographic Characteristics and Rates of Co-morbidities. In this gender $\chi 2 = 89.25$; $p<0.0005$; age $\chi 2 = 339.575$; $p<0.0005$; Education degree $\chi 2 = 558.915$; $p<0.0005$; Job $\chi 2 = 290.388$; $p<0.0005$; Marital status $\chi 2 = 1641.85$; $p<0.0005$; Social support $\chi 2 = 226.938$; $p<0.0005$; and Socioeconomic status $\chi 2 = 513.961$; $p<0.0005$.

Table 3. **Patients' Socio-demographic Characteristics and Rates of Co-morbidities**

Variables	Frequency [a]	Disease	Frequency [a]	$\chi 2$	P-Value
Gender				89.250	0.0005 [b]
Female	256 (33)	Mood disorders	81 (10.5)		
Male	519 (67)	Anxiety disorders	68 (8.8)		
Age(yrs)				339.575	0.0005 [b]
≤ 40	18 (2.3)	Sleep disorder	90 (11.6)		
41-50	125 (16.1)	Mood-Anxiety	60 (7.8)		
51-60	328 (42.3)	Mood-Sleep	15 (1.9)		
≥ 61	304 (39.2)	Anxiety-Sleep	24 (3.1)		
Education degree				558.915	0.0005 [b]
Illiterate	318 (41.1)	Sleep-Personality	4 (0.5)		
Primary	220 (28.4)	Mood-Anxiety-Sleep	15 (1.9)		
Less than diploma	26 (3.4)	Mood-Anxiety-Personality	3 (0.4)		
Diploma	119 (15.4)	Cigarette	306 (39.5)		
Bachelor	87 (11.2)	Addiction	126 (16.3)		
MA and PhD	4 (0.5)				
Job				290.388	0.0005 [b]
Clerk	74 (9.6)				
Self-employed	184 (23.8)				
Retired	180 (23.3)				
Housekeeper	242 (31.3)				
Farmer	83 (10.7)				
Unemployed	11 (1.4)				
Marital status				1641.85	0.0005 [b]
Married	678 (87.6)				
Divorced	88 (11.4)				
Separated	6 (0.8)				
Single	2 (0.3)				

Social support		226.938	0.0005 [b]
Appropriate	188 (24.3)		
Average	453 (58.5)		
Weak	133 (17.2)		
Socioeconomic status		513.961	0.0005 [b]
High	53 (6.8)		
medium	547 (70.7)		
Low	174 (22.5)		

a Data are presented as No. (%).

b Significant difference between patients for each characteristic P < 0.01.

As **proven** in Table 3, the **guys** are **two times** as **one-of-a-kind women** patients ($\chi2 = 89.250$, df (1), P<**zero**xss=**eliminated**xss=**eliminated**xss=**eliminated**xss=**eliminated**xss=**eliminated**xss=**eliminated**>

Discussion

A high level of cooperation rate and adherence to CR are required to reduce cardiovascular illnesses and must deal with MI patients. The rates for printed material with information (86%) and lent for a return (80%) to the CR among all sick occurrences of MI-person being treated for medical problems show up extreme when it comes into view differently concerning the arrangement. Orderlies for the CR are alluding to male humans, younger and with reduced co-morbidities. This slant is also in the direction of this assessment. People address 71% of all sick MI-persons 75 years old or older who are being treated for medical problems (25).

In this study, A total of 831 patients (231 females and 600 men) participated in the current study. Age of the individuals was 58.26 ± 9.10 years (58.89 ± 8.29 in women and 57.95 ± 9.46 in men). Moreover, the age range was 29–82 years old (29–78 years in women and 31–82 years in men). In this study, patients' socio-portion credits and speeds of co-morbidities in heart patients were studied. The risk factors that contributed to the present patient's emotions were investigated. Psychological segments (36.3%), natural substances (4.3%), and biological aspects (3.8%) were also highlighted separately. Most individuals who are unaware of their condition (even without a concealed hint) is 10.4 %, which is quite concerning. Patients in this research underwent numerous therapies, including heart reconstruction as a last choice. In any case, after the clinical gathering is complete, the rate at which patients don't know why they have a problem might call into question therapies that supervise the hospital's basic prosperity and benefits (26). The major problem is the lack of understanding of many patients about how to justify their disorder. The low recall-rate, covering 10.4% of patients, is the baseline (18).

During this thorough examination, patients are also enrolled in the CR via bedside interviews, and by any means to the SRP. The mutual effort rate (certain among all surrendered persons being treated for medical problems) was 70% for the person being treated for medical problems, an occurrence MI diverged from 85% in this appraisal (26). There are no differentiations in the fashionable investment rate displayed by male or female gender, age, informational level, or person's character with patients hinted at in the CR. The dismissal rate (1.5%) and non-mutual effort rate (3%) are incredibly reduced, though taller among people treated for medical problems present in the SRP (27).

There are contrasts in attitudes concerning socio-portion factors. As can be seen, there is a colossal differentiation between males and females regarding their mindsets toward the explanations behind contamination concerning socio-section factors. For example, it is understood that women are zeroing in on mental peril factors ($\chi2 = 517.00$, P < 0.0005) while men are more focused on lead risk factors ($\chi2 = 599.00$; P < 0.0005) (28).

Conscious following in patients' position or time, the one bear has not been contactable all along with therapy and evaluation for socially weak points, regardless of how efficient the centre register for new sick MI patients, the SRP bear joins the guidelines as urged by the European Association of Cardiovascular Anticipation and Rehabilitation (29).

In this approach, testimonials of good character for the CR happen significantly more frequently than for standard medical care. Since the reference and mutual effort rates happen so frequently while introducing protection, there may be a rooftop sway. Cultured and fashionable additions to the clinical centre scene can create a taller effect. 22% of agreed patients lived in unique homes. A level of exhaustion of 46% of a person being treated for medical problems recommended the ERP. When attempting to lead the organisation into understanding the ERP, a disproportionate number of patients were encountered. Socially feeble patients may be arranged into three parties (30).

The first and reasonably little accumulated contained detract person being treated for the medical problem the one experienced addiction or concerning the mind examinations, the one got to move the payment for work, or the one populated the city. A second gathering of concerning polite society dainty patients happen unemployed or in danger of an activity in which one must lose their work, bear extinct their social position or permissive community, and conceivably meet clashes. An after the second tremendous body of the person being treated for medical problem having complete, friendly ties, were make use of, by any means bear a low educational level, lived unique, and maybe bear possible co-morbidities (31).

Attitudes towards staff and patients being treated for medical problems can change as the temporal length of the event or entity's existence continues, and extensive stretches of regimen exist because grant permission has led just before to a more real need for gatherings following in position or time discharge from clinical convenience. We can't concentrate on the causality of the stirring stick, the motivation of a person being treated for a medical problem, a single method, social, military, and extreme interest in the estimate. By any means, the cooperation rate for CR can and should be made better, especially concerning the welfare of humankind's frailest individuals being treated for medical problems. The low printed matter with information, mutual effort, and adherence rates between weak social occasions happen a test to good fortune progression fashionable two together with the dispassionate facility and community. An exact hide and perhaps full of enthusiasm methods in becoming adjusted accompanying a polite society isolated engineer may be a key to connecting more occupants at risk for able to be averted sicknesses fashionable affluence progression satisfy. Different amount in the flexibility of the method should be done (26).

Conclusion
The findings of the current study imply that social unlikeness fashionable citation, authorization, and devotion to the CR may be managed by exact reference and regarding the welfare of humanity's unique distinguish approach. It is likely to address low similarly and amazingly instructed person being treated for a medical problem, folks, woman, and person being treated for the medical problem of another identity in consideration of the CR in the strange and wonderful custody. It is likely to prepare recovery staff to use agreement-average, affecting gathering, and additional patient-cause-to happen method. It is within reach to gain the confidence of low-learned and concerning polite society unable patients to hold active to an alone and concerning the welfare of humankind isolated CR.

Conflict of Interests
The author reports no conflicts of interest regarding the current study and the writing of this paper.

References
1. Tüchsen F, Endahl LA. Increasing inequality in ischaemic heart disease morbidity among employed men in Denmark 1981−1993: the need for a new preventive policy. Int J Epidemiol 1999;28:640−4.
2. Ickowics JR, Viscoli CM, Horwitz RI. Functional recovery after myocardial infarction in men: the independent effects of social class. Ann Int Med 1997;127:518−25.
3. Mackenbach JP, Bos V, Andersen O, Cordano M, Costa G, Hardiong S, et al. Widening socioeconomic inequalities in mortality in six Western European countries. Int J Epidemiol 2003;32:830−7.
4. Biagini E, Schinkel AFL, Bax JJ, Rizzello V, van Domburg RT, Krenning BJ, et al. Long term outcome in patients with silent versus symptomatic ischaemia during dobutamine stress echocardiography. Heart 2005;91(6):737−42.
5. Shadia SN, Kundu SK, Hossain MdD, Ultrasonographic assessment of retroverted gravid uterus and first trimester pregnancy loss of women in a semi-urban area of Dhaka, Bangladesh, SPR, 2021;1(3): 70 - 76.
6. Nabel EG. Cardiovascular disease. New England Journal of Medicine. 2003 July 3;349(1):60-72.
7. Ayers S, Eagle A, Waring H. The effects of childbirth-related post-traumatic stress disorder on women and their relationships: a qualitative study. Psychology, health & medicine. 2006 Nov 1;11(4):389-98.
8. Turner JA, Dworkin SF. Screening for psychosocial risk factors in patients with chronic orofacial pain: recent advances. The Journal of the American Dental Association. 2004 August 1;135(8):1119-25.
9. Saeidi M, Soroush A, Komasi S, Moemeni K, Heydarpour B. Attitudes toward cardiovascular disease risk factors among patients referred to a cardiac rehabilitation center: importance of psychological attitudes. Shiraz E Medical Journal. 2015;16(7):1-3.
10. Charter RA, Lopez MN. Millon Clinical Multiaxial Inventory (MCMI-III): The inability of the validity conditions to detect random responders. Journal of Clinical Psychology. 2002 Dec;58(12):1615-7.
11. Jackson L, Leclerc L, Erskine Y, Linden W. Getting the most out of cardiac rehabilitation: a review of referal and adherence predictors. Heart 2005;91:10−14.
12. Deng CG, The dietary diversity and rural households' nutrition security in Itang special district, Gambella, Ethiopia, SPR, 2021;1(4): 258– 263.
13. Shadia SN, Kundu SK, Hossain MdD, Ultrasonographic assessment of retroverted gravid uterus and first trimester pregnancy loss of women in a semi-urban area of Dhaka, Bangladesh, SPR, 2021;1(3): 70 - 76.
14. Statistics Denmark, Danish Ministry of Education (Danmarks Statistik, Under visning sministeriet). DUN 2001. Dansk Uddanne lses-Nomenklatur. Copenhagen: (www. Danmark sstatistik.dk) DanmarksStatistik; 2002.
15. Albus C, Waller C, Fritzsche K, Gunold H, Haass M, Hamann B, Kindermann I, Koellner V, Leithaeuser B, Marx N, Meesmann M. Significance of psychosocial factors in cardiology: update 2018. Clinical Research in Cardiology. 2019 Nov;108(11):1175-96.
16. Kang K, Gholizadeh L, Inglis SC, Han HR. Correlates of health-related quality of life in patients with myocardial infarction: A literature review. International journal of nursing studies. 2017 August 1;73:1-6.
17. Fulghesu, A. M., Ciampelli, M., Belosi, C., Apa, R., Pavone, V., and Lanzone, A. A new ultrasound criterion for the diagnosis of olycystic ovary syndrome: the ovarian

stroma/total area ratio. Fertil. Steril.,76:326–331, 2001.

18. Poretsky, L., and Piper, B. Insulin resistance, hypersecretion of LH, and a dual-defect hypothesis for the athogenesis of olycystic ovary syndrome. Obstet.Gynecol.,84:613–621, 1994.

19. Hemmingway H, Marmot M. Evidence based cardiology.Psychosocial factors in the aetiology and prognosis of coronary heart disease: systematic review of prospective cohort studies. BMJ 1999;318:1460−7.

20. Statistics Denmark, Danish Ministry of Education (Danmarks Statistik, Under visning sministeriet). DUN 2001. Dansk Uddannelses-Nomenklatur. Copenhagen: (www.danmark sstatistik.dk) DanmarksStatistik; 2002.

21. Gupta R, Gupta P, Gupta S, Garg S. Comparative evaluation to determine the efficacy of conventional radiography, digital radiography and ultrasound imaging in the diagnosis of periapical lesions. SPR, 2021; 1(3):138 - 143.

22. Corrà U, Piepoli MF, Carré F, Heuschmann P, Hoffmann U, Verschuren M, et al. Secondary prevention through cardiac rehabilitation: physical activity counselling and exercise training: key components of the position paper from the Cardiac Rehabilitation Section of the European Association of Cardiovascular Prevention and Rehabilitation. Eur Heart J 2010;31(16):1967−74.

23. Bhingardive VV, Sivabalan T, Effectiveness of Information Booklet on Knowledge, Attitude and Practice on Cardiac Rehabilitation among Myocardial Infarction Patients, 2017; 6(1):5-9.

24. Attitude and practice on Cardiac Rehabilitation among patients suffering from myocardial infarction; Retrieved from https://sites.kowsarpub.com.

25. Singh I. Assessment and Management of Older People in the General Hospital Setting. In: Jr., E. T. Z. , editor. Challenges in Elder Care [Internet]. London: IntechOpen; 2016 [cited 2022 Mar 01]. Available from: https://www.intechopen.com/chapters/51670 doi: 10.5772/64294

26. Annual report 2020-2021, Department of Health & Family Welfare Ministry of Health & Family Welfare Government of India, 2021, https://main.mohfw.gov.in/ sites/default/files/Annual%20Report%202020 -21%20English.pdf

27. Hawkins BS, Prior MJ, Fisher MR, Blackhurst DW. Relationship between rate of patient enrollment and quality of clinical center performance in two multicenter trials in ophthalmology. Control Clin Trials. 1990 Oct;11(5):374-94. Myocardial infarction; Retrieved from https://journals.sagepub.com.

28. Malhotra S, Shah R. Women and mental health in India: An overview. Indian journal of psychiatry, 2015;57(Suppl 2), S205–S211.

29. Socially differentiated cardiac rehabilitation; Retrieved from https://www.capegeorge.org

30. Institute of Medicine (US) Committee on Prevention of Mental Disorders; Mrazek PJ, Haggerty RJ, editors. Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. Washington (DC): National Academies Press (US); 1994. 6, Risk and Protective Factors for the Onset of Mental Disorders. Available from: https://www.ncbi.nlm.nih.gov/books/NBK236 306/

31. Heather N. Is the concept of compulsion useful in the explanation or description of addictive behaviour and experience?. Addict Behav Rep. 2017;6:15-38. Published 2017 May 18. doi:10.1016/j.abrep.2017.05.002